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Framing the pandemic: Multiplying "crises" in Dutch healthcare governance during the emerging COVID-19 pandemic

Bert de Graaff *, Sabrina Huizenga, Hester van de Bovenkamp, Roland Bal

Erasmus School of Health Policy & Management, Erasmus University Rotterdam, Rotterdam, the Netherlands

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ABSTRACT

In this paper we explore the impact of the emerging COVID-19 pandemic on the governance of healthcare in the Netherlands. In doing so, we re-examine the idea that a crisis necessarily leads to processes of transition and change by focusing on crisis as a specific language of organizing collective action instead. Framing a situation as a crisis of a particular kind allows for specific problem definitions, concurrent solutions and the inclusion and exclusion of stakeholders. Using this perspective, we examine the dynamics and institutional tensions involved in governing healthcare during the pandemic.

We make use of multi-sited ethnographic research into the Dutch healthcare crisis organization as it responded to the COVID-19 pandemic, focusing on decision-making at the regional level. We tracked our participants through successive waves of the pandemic between March 2020 and August 2021 and identified three dominant framings of the pandemic-as-crisis: a crisis of scarcity, a crisis of postponed care and a crisis of acute care co-ordination. In this paper, we discuss the implications of these framings in terms of the institutional tensions that arose in governing healthcare during the pandemic: between centralized, top-down crisis management and local, bottom-up work; between informal and formal work; and between existing institutional logics.

1. Introduction

When the COVID-19 pandemic emerged, healthcare organizations were forced to learn how to manage what was, at the time, a novel coronavirus under conditions of great uncertainty about the virus itself, the disease it caused, the broader societal effects of the pandemic and the policy measures meant to contain it (Wallenburg et al., 2021). At the moment, the COVID-19 pandemic is slowing down and more formal evaluations of government responses are being published (Sachs et al., 2022), but little is known about its impact on the organization of healthcare. International studies point to the pandemic's impact on different levels of the healthcare system, e.g. on number of consultations with general practitioners (Deml et al., 2022), the waning levels of staff commitment as the pandemic progressed (Gifford et al., 2022), and patients' clinical condition (de Lange et al., 2022). We do see evidence of continuous strain on healthcare systems due to staff shortages and the constant pressure of treating COVID and post-COVID patients and working through waiting lists of regular patients whose care was postponed (Mizee et al., 2022).

In this paper we explore the impact of the emerging COVID-19 pandemic on the governance of healthcare in the Netherlands, focusing on the regional level. We do so by re-examining the idea that a crisis, such as the pandemic, necessarily leads to processes of transition and change as is suggested in the literature (Koselleck and Richter, 2006, p. 387). Instead, we argue that crises do not necessarily lead to swift adaptations, nor is such change necessarily negative as "the talk about bads [can also] produce(s) 'common goods'" (Beck, 2015, p. 78) and open-up new normative horizons. Crises are said to have emancipatory side-effects that lead to a slow "metamorphosis" of the social and political order, leaving open "wide gaps of not-knowing" (Beck, 2015, p. 77). Revolutions and other modes of impact are thus contingent and not necessary outcomes of a moment of crisis, and organizations do not necessarily learn from such moments. In the case of the COVID-19 pandemic, this is exemplified by the conclusion that the world is "dangerously unprepared for the next pandemic" (Clark et al., 2022, p. 1996). In our analysis, we depart from the literature focusing on a crisis as a discursive act, as a way of framing the pandemic-as-crisis, and emphasize the contingency rather than the necessity of change during the pandemic. This approach allows us to explore the emergence of collective action and change in the governance of healthcare through

* Corresponding author. Burgemeester Oudlaan 50, 3062 PA, Rotterdam, the Netherlands.
E-mail address: degraaff@eshpm.eur.nl (B. de Graaff).

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moments of crisis.

This paper is based on our multi-sited ethnographic study of the shared response of Dutch healthcare organizations to the pandemic, focusing on the crisis organization, in particular the regional collaborations, that emerged to deal with the pandemic (cf. Bal et al., 2022; de Graaff et al., 2021; Wallenburg et al., 2021). We explore the impact of the pandemic by describing three dominant ways of framing the pandemic as a crisis, an analysis that emerged inductively during our fieldwork in the Netherlands starting in early March 2020. Our fieldwork came to focus mainly on crisis decision-making at the regional level and led us to wonder how healthcare organizations act together during moments of great uncertainty and how such collective action emerged and subsided concurrent with the changing definitions of the problem at hand.

1.1. The pandemic-as-crisis

The crisis literature conceptualizes a crisis as both a concrete process of transition and decision-making and a structural condition of modernity (Koselleck and Richter, 2006). This underscores how "the concept [crisis] remains as multi-layered and ambiguous as the emotions attached to it" (Koselleck and Richter, 2006, p. 358). With crisis-talk also infusing everyday language (and therefore blurring academic use), we define "crisis" in this paper as a discursive act, arguing that specific crises are constituted in and through language (Hay, 1996). We examine the impact of the pandemic on the governance of healthcare by exploring how crisis language reflects but also shapes collective action by framing the pandemic-as-crisis in multiple ways (Jaworski and Coupland, 1999; Yanow, 2000).

Little is known about emergent collective action during crises. Crisis management literature points to the need to understand such responses as self-organizing response systems (Ansell et al., 2010, p. 203), a 'bricolage' of practices (Ansell and Boin, 2019). The role of language and framing is generally understood through (leaders') risk communication and processes of 'meaning-making' (Boin et al., 2021) – similar to literature on collaborative governance (Ansell and Gash, 2008). One crucial study by Beck and Plowman (2014) into the collective response to the Columbia space shuttle crash emphasizes the importance of emergent self-organization, trust and (collective) identity, with the latter being shaped by language, according to the authors (Beck and Plowman, 2014, p. 1248). In this paper, we explore how emergent collective action in Dutch healthcare dealt with the manifold uncertainties of the pandemic through the language of crisis and consider how what counts as a crisis worthy of public concern and collective action needs to be actively articulated as such (Marres, 2007). Such (symbolic) articulations of a crisis operate as frames, making sense of and giving meaning to a situation (Orlikowski and Gash, 1994). Framing a situation in a certain way reduces ambiguity and complexity and creates a structured, coherent narrative with specific aspects being foregrounded or ignored. This in turn guides or legitimizes certain practices and actions (Rein and Schön, 1993; Stone, 2012). For instance, specific ways of epidemiological and mathematical modelling helped to frame the (potential) pandemic-as-crisis and legitimate non-pharmaceutical public health measures, such as lockdowns (Rhodes and Lancaster, 2022).

Crisis framing thus offers specific ways of defining a situation, the collective and public involved and legitimizes specific ways of knowing and feeling (cf. Hochschild, 1979). Crises can, as such, be made more or less "public" over time in processes of (de)politicization (Oosterlynck and Swyngedouw, 2010) and offer a specific language of governing healthcare during a pandemic. For example, the framing of the COVID-19 pandemic as a predominantly national-level concern hampered cross-border cooperation for emergency services when border control practices were re-established in Europe (Dieminger et al., 2022). The COVID-19 pandemic could thus potentially be a crisis of many different sorts, and in some situations might not even be framed as "crisis" in the first place. For instance, Lopez and Neely (2021) argue that we might be witnessing the advent of a more caring society with a renewed awareness of the relevance of care.

Framing the pandemic as a crisis of a specific kind impacts the way the healthcare system organized its pandemic response as it generates a specific definition of stakeholders, problems and solutions that can spark concrete tensions between different framings and also allow actors to exploit the situation at hand (Boin et al., 2009). In the UK, for example, the focus on a specific group of scientists allowed a flawed framing of how SARS-CoV-2 is transmitted (emphasizing droplets instead of airborne transmission) to become entrenched in UK crisis policy (Greenhalgh et al., 2022). Dominant ways of framing the pandemic-as-crisis can thus be distinguished from non-dominant ways. Following Hajer, a dominant discourse is topical and can be situated in particular practices as it structures and is to some extent institutionalized in decision-making processes (Hajer, 2005, p. 8). It thus "exclude[s] alternative ways of thinking and acting" (Bröer, 2008, p. 97).

To frame the pandemic-as-crisis of a particular kind thus has clear and discernible consequences, for instance in the concrete practices of sense-making during crisis decision-making (Kornberger et al., 2019), and gives rise to tensions in these practices. It is to these practices and tensions that we turn to in this paper on regional cooperation between healthcare organizations in the Netherlands. We zoom in on three dominant framings of the pandemic-as-crisis in the organization of healthcare, focusing on the definition of the crisis at hand, its proposed solutions and the inclusion and exclusion of relevant stakeholders. This allows us to consider the dynamics and contingencies of the collective action undertaken by our participants, instead of assuming organizational change and learning through crisis.

2. Method

This paper is based on in-depth qualitative data gathered in the Netherlands between early March 2020 and August 2021 as part of a multi-sited ethnographic study on the COVID-19 crisis organization in Dutch healthcare, particularly on the regional level.

2.1. Context: Regional networks for acute care delivery (ROAZ) in the Netherlands

The Dutch healthcare response to the COVID-19 pandemic can be sketched as an attempt to balance a process of national centralization against consensus-based decision-making with relevant and prominent stakeholders and experts (Wallenburg et al., 2020). This balancing act coincided with an existing regionalization effort and a system of regulated competition between healthcare providers introduced into the layered Dutch healthcare system earlier this century (Jeurissen and van Ginneken, 2019; van de Bovenkamp et al., 2017). Regional networks for acute care delivery (hereafter, ROAZ) became crucial sites for the pandemic response and the focus of our fieldwork. ROAZs are networks of independent providers of acute care in the Netherlands. The networks are mandated by law, supported by a small number of staff and generally operate from a university hospital that serves as a regional hub. ROAZs consist of an administrative layer of mandated representatives of the network partners and a tactical layer where the partners' managements consult about implementation issues. The ROAZ networks coordinate the supply, accessibility and quality of acute care in the region. There are ten such acute care regions in the Netherlands covering the entire country. ROAZ network partners met about twice a year before the pandemic, daily at the height of the pandemic, and less frequently as the waves subsided. In theory (but not in practice), ROAZs operate independently from existing public health agencies. They are not designed as a crisis organization in terms of content, network partners and modes of decision-making, unlike the Dutch public health agencies. They are instead based on long-term inter-organizational collaboration in specific areas such as acute cardiology or obstetrics. Decisions in a ROAZ are

made by seeking consensus between the representatives involved, with the dominant (university) hospitals playing an important role in specific regions. The system of regulated competition means that consensus between providers of acute care is not automatic. Moreover, the ROAZs have a limited formal mandate; strategic and financial decisions lie with individual organizations in interaction with healthcare insurers and not with the ROAZ networks as such. At the national level the ROAZ networks unite in the National Network for Acute Care (hereafter, LNAZ), which during the pandemic got a strong presence in the national-level crisis organization.

2.2. Case studies: ROAZ Blue, ROAZ Red and ROAZ Yellow

Our ethnographic inquiry into the crisis organization in Dutch healthcare started early March 2020, just before the first COVID-19 death was formally registered in the Netherlands. We started this study at the university hospital in the ROAZ Blue network (names are pseudonyms) through our existing informal contacts. *ROAZ Blue* is divided into three sub-regions, with one urban region and its five hospitals being dominant. The ROAZ Blue staff office is housed in the university hospital, along with the regional coordination center for patient distribution (hereafter, RCPS). The ROAZ Blue region had a hard time in the first wave of the pandemic (until the summer of 2020) but was helped by its intimate relationship with the national level. Despite the ongoing pandemic that put enormous stress on our fieldwork, we were able to build on the trust and relationships we established in the spring and summer of 2020, and extended our research to the ROAZ Red and ROAZ Yellow networks in autumn 2020. *ROAZ Red* lacks a large university hospital in its network but has three large, four medium-sized and three smaller hospitals. Several of these have tertiary functions such as a trauma center, complex oncological care and cardiac surgery. The ROAZ Red region was forced to take on the role of front line when the first wave of the pandemic washed over the regional hospitals. Close cooperation in the region led, among other things, to the establishment of the Dutch National Coordination Center for Patient Distribution (hereafter, LCPS), supporting the central/national coordination of patient flows. *ROAZ Yellow* covers three Dutch provinces. Like ROAZ Blue, ROAZ Yellow's office is located in a university hospital. Before the pandemic, ROAZ Yellow was actively involved in a program tackling staff shortages in the region that had resulted in close cooperation between hospitals. The ROAZ Yellow region had the lowest influx of COVID-19 patients from its own region and collaboration with the national level did not immediately go well here. ROAZ Yellow maintained a somewhat autonomous position throughout the pandemic.

2.3. Multi-sited ethnography

In this paper we build on data collected from March 2020 to August 2021, consisting of a total of 446 h of non-participant observations of ROAZ meetings and interviews with a broad array of participants (see Table 1). Initially, our research aimed at understanding the emerging crisis-organization in one university hospital in the context of ROAZ Blue, but after the summer of 2020 we moved to grasping the emerging collective action in other ROAZ-regions as well, in the context of national level developments. ROAZ Blue was selected through convenience, ROAZ Red and Yellow were selected purposively based on existing responses to the pandemic (see above), differences in the positioning of hospitals in the regions and geographical spread.

Table 1
Sources of data.

Source	Observations (hours)	Interviews (participants)
University hospital	210	29
ROAZ Blue	110	14
ROAZ Yellow	29	15
ROAZ Red	65	16
LCPS/LNAZ	24	8
Other ROAZ regions	8	18
National-level actors	0	12
Total	**446**	**112**

Non-participant observations and (follow-up) interviews were conducted in person and on-site, but as the pandemic progressed and policy measures increased, we tracked our participants online and then offline again when possible. During our fieldwork, we adjusted our ongoing data collection to the emerging questions and theoretical concepts that we found useful in structuring our thoughts (for instance by adding topics to interview guides). Hence, the specific focus of our observations and interviewed were tailored to the specific situation and participants at hand. In the first interviews we focused on the emerging crisis-response in ROAZ Blue. The interviews that followed after the summer of 2020 were aimed at understanding the 'chronic crisis' into which the pandemic turned, specifically focusing on interactions in and between the ROAZ regions – hence also our inclusion of national-level actors.

Within the context of our case studies, we attended ROAZ board meetings, visited ROAZ offices and, after snowball sampling, interviewed relevant actors in the specific ROAZs we were focusing on, such as hospital representatives, office managers and patient distribution coordinators. Alongside the in-depth case studies, we conducted interviews (N = 18) with actors in the seven other ROAZ regions, specifically ROAZ chairpersons and ROAZ office managers as well as representatives of the public health organization in two regions. In addition, we attended several LNAZ meetings during this period, and took a closer look at the LCPS. The LCPS is administered by the LNAZ and arranges supra-regional patient distribution. We conducted observations in the LCPS control and coordination room (24 h) and eight semi-structured interviews with LCPS directors and managers (3), employees and managers of the knowledge center (3), the patient distribution coordination manager (1), and the communication manager (1). Finally, we had several interviews with national actors (N = 12), specifically representatives of the Dutch Health and Youth Care Inspectorate (IGJ), the Dutch Healthcare Authority (NZa), the Ministry of Health (VWS), a public health organization (GHOR NL), organizations of intensive care specialists (NVIC) and general practitioners (LHV), the Dutch Health Council (GR), client councils (LOC) and the Netherlands Institute for Social Research (SCP).

2.4. Data analysis

During data-gathering, we analyzed our data inductively through several iterations, checking it against theoretical concepts that would help in interpreting what we had found (Tavory and Timmermans, 2014). We organized six sessions in which we reflected on our preliminary findings with key participants, one in each of the three ROAZ regions we were focusing on and three aimed at the national level. While primarily concerned with helping the healthcare crisis organization, these meetings also served as member checks on our results. In this paper, we specifically focus on the framing of our participants during interviews and our observations, i.e. how participants delineated problem definitions and concurrent solutions, how they included or excluded public stakeholders from processes of decision-making and which tensions these framings caused in the healthcare crisis organization. For this analysis we focused on the data from the three ROAZ-regions, with the other data, such as our observational data at LNAZ and LCPS, providing the necessary context to explore the framings we identify. Because our fieldwork lasted about 18 months we were able to consider how dominant framings of the pandemic-as-crisis shifted over time. We also differentiated between framings of public health measures, such as the Dutch vaccination strategy, and those addressing the crisis within the healthcare system itself, limiting our categorization of dominant framings to the latter.

2.5. Ethics

Our research has been positively assessed by the Research Ethics Review Committee of the Erasmus School of Health Policy & Management (20-08 Bal; 21-09 Bal). We obtained prior and explicit informed consent from the participants for observations and interviews; none of our participants declined. The quotes used in this paper have been approved by the relevant participants, whose data has been pseudonymized.

3. Results

Below we identify the three dominant framings of "the crisis" that emerged at different times during the pandemic in the Dutch healthcare crisis organization: a crisis of scarcity, a crisis of postponed care and a crisis of acute care coordination. We describe each one by focusing on the definition of the crisis at hand, its proposed solutions and the inclusion and exclusion of relevant stakeholders.

3.1. Crisis of scarcity

At the start of our fieldwork, scarcity quickly became a major theme:

> We affluent Dutch people - who are so used to pressing a button and there it is - are now being confronted with "yes, but it might not be there this time." And that is of course a huge change.
>
> (Interview with virologist, 2020)

The pandemic-as-crisis was defined from the very start as a transformative crisis of scarcity: scarce intensive care capacity, test material, bandage, respirators and personal protective equipment (PPE), with the facemask becoming iconic:

> Everyone seems to be working on this full-time, 24/7, since last Thursday [27/2/2020]. It's about very basic things: are there enough swabs ("only for 6 days") and facemasks, and how to distribute them. … For example, there are too few swabs because the necessary baton comes from China and China isn't delivering at the moment. Bandage is also becoming scarce for the same reason. The facemasks come up a lot in discussions.
>
> (Excerpt from observations, university hospital, 2020)

The framing of scarcity as the crisis at hand seemed to push established institutional logics into the background. Managing care through the dominant institutional logic of competition (both between and within hospitals) was much less explicit. Instead, participants foregrounded talk about trusting professionals and a "can do" mentality to cope with the acute crisis:

> First of all, the agreement in [ROAZ Red] is: we help each other … What you also saw at the time was that solidarity grew as we went through the work. The feeling that we needed each other.
>
> (Interview with hospital administrator, 2021)

The start of the pandemic was hence framed as an emotional but also powerful moment of solidarity in the face of a unique situation. The initial notion was that this pandemic-as-crisis could be resolved through collective action flowing from this powerful moment, although in fact such action does not come about in and of itself. PPE shortages were framed as a problem for regions or individual providers to solve. For example, the university hospital in ROAZ Blue quickly distributed its relatively large stock to care providers within the region, as an act of regional solidarity – although mostly aimed at curative care, with its purchasers playing an important role in identifying and buying stocks of PPE for the region. We see similar actions in other regions: collective action was initially decentralized and regional, stemming from the ROAZs and existing informal networks of intensive care specialists. This focus on the regional level grew sharper when coordination on PPE with the national government faltered at first. National-level involvement was initially seen as disruptive to the structures that had been established at regional level, for example regarding the provision of information on quality standards.

The emphasis on the regional level became even clearer when ROAZ Red decided to redistribute intensive care patients between regional hospitals to manage scarce capacity in ICUs. The situation soon became even more untenable for the local hospitals and elective care was scaled down. This also affected other regions, with the situation for the ROAZs changing very rapidly during the first few weeks of the pandemic. Help was needed to distribute patients between regions in the Netherlands, "to relieve the pressure on hospitals," as the argument went. This help was provided by LNAZ (the joint ROAZ networks at the national level), aided by the Dutch military (with the accompanying precision and jargon). The LCPS, established as a national coordination center for patient distribution, built explicitly on the existing regional actions; each ROAZ would have an RCPS, i.e. a regional coordination center for patient distribution, based on the example of ROAZ Red. The LCPS assumed a coordinating role, for example by surveying scarce capacity in hospitals. Supra-regional distribution was not without a struggle, however; transparency of data between organizations that were competitors (on paper and outside the pandemic) was the subject of ongoing debate (and remains so). The framing of the pandemic-as-crisis of scarcity was also productive of a particular collective in healthcare; the problem was mainly seen to lie with intensive care capacity and stocks of PPE, emphasizing acute care delivery and hospitals in particular. Other parts of the healthcare system, such as nursing homes and home care, were less visible in this pandemic-as-crisis and the first phase of the pandemic in the Netherlands.

At the start of the pandemic in the Netherlands, our participants were in search of the right level of decision-making. Much of the initial response was at a decentralized level; in the case of both patient distribution and PPE supply, regional actors took the initiative and displayed the necessary adaptive capacity. Existing networks, including the ROAZs, and the informal communication and coordination that they enabled made an important contribution to rapid crisis decision-making and care management. Tensions between regional and national levels remained throughout the pandemic. The design of the ROAZ networks and the specific framing of the crisis as one of scarcity in intensive care capacity and PPE in hospitals initially meant that the crisis organization we studied paid relatively little attention to problems outside hospitals and acute care. Less dominant and vocal sectors of the Dutch healthcare system, such as nursing homes (which experienced a relatively large number of COVID-19 deaths), were overlooked at this stage.

3.2. Crisis of postponed care

When the first wave of the pandemic subsided, there was a brief respite in the early summer of 2020 that allowed healthcare organizations to take stock. One of the conclusions during this period was that regular care, now all lumped together as "non-COVID" care, had been scaled down too severely in the spring of 2020 leading to a growing backlog of care (LNAZ, 2020, p. 5). This is the second framing of the pandemic-as-crisis that we can detect in our material: a crisis of postponed care. The main issue in this pandemic-as-crisis now moved from acting in solidarity to hold back the waves of patients suffering from COVID-19 to striking a precarious balance between COVID and non-COVID care, meaning not fully "down-scaling" non-COVID care in favor of COVID-related care.

Participants admitted that this balancing act between COVID and non-COVID care was difficult, for one thing because it meant that organizations had to keep working at maximum capacity without overstretching. The argument was that this could be achieved by sharing data on capacity, using reliable models, tight forecasts and strict coordination based on those models, while stressing innovations in healthcare, for example the use of e-Health applications and telemonitoring. At

the national level, inter-regional distribution of intensive care capacity was plotted based on a fixed "basic capacity" per region using a "fair-share" principle. The burden of COVID-19 care was to be divided equitably among and within the acute care regions. To arrive at this fair share, real-time insight into hospital capacity was needed, something not easily attained:

> We present our figures transparently. And there are still regions that do not share their own [data], especially with the upscaling and downscaling of regular care. Yes, you know, if you want to maintain support, you have to be transparent. And then you must have the courage to share that with each other.
>
> (Interview with doctor at RCPS ROAZ Red, 2021)

The quote cites trust, and courage, as necessary for balancing COVID and non-COVID care between regions and hospitals. Sharing the necessary data for patient allocation required an unremitting and labor-intensive effort on the part of the ROAZ offices, however. Three times a day, the ROAZ regions transferred data to the LCPS. Existing infrastructures, such as the national register of ICU patients (NICE), were not always up to date and not everyone trusted the new systems – the professionals we interviewed relied instead on informal professional networks, subverting the national coordination effort. Moreover, a top-down call to relocate a patient often conflicted with patient-doctor – and family – relations:

> An empty bed is not necessarily an available bed and that's why there's always a "mutual conversation."
>
> (Observations, RCPS ROAZ Red, 2021)

As a result, the distribution of patients and the validity and necessity of data were ongoing matters of debate between and within the ROAZ networks, causing frictions between network partners and the regional networks, with the latter still being dominated by the hospitals, a consequence of the persistent focus on intensive care capacity. These frictions were relevant because they concerned the levels of production individual hospitals might still achieve. Unlike the "crisis of scarcity" (which evoked a sense of solidarity), this second framing of the pandemic-as-crisis rekindled the interests of the regulated market and competition among our participants. These interests play out at different levels and negotiating positions are complex, as a hospital administrator – representing his organization in a ROAZ network – describes:

> Those hospital administrators, whether they are doctors or professional administrators, are in a bind, because they are in the ROAZ network, to which they must contribute, but they are also part of their own organization and they also must deliver there.
>
> (Interview with hospital administrator, ROAZ Red, 2021)

Cooperation in a ROAZ network is often at odds with the normally dominant market discourse in which organizations are supposed to compete. On the one hand, by participating in the ROAZ, administrators work together to cover the ROAZ region. On the other hand, they still manage an individual hospital where a constituency of partnerships and physicians expected the administrator to lobby for their interests – in this case, to make care for non-COVID patients possible.

The framing of the pandemic as a crisis of postponed care emphasized the possibility of adaptation during an ongoing pandemic and the limitations posed both by the pace required to keep up with wave after wave and the existing institutional arrangements. Efforts to coordinate the distribution of patients once again highlighted the ongoing tensions between centralized and decentralized management of the healthcare crisis organization, and between more formal modes of decision-making (national-level coordination) and informal, relational ways of doing so (professional networks). The sense of solidarity in healthcare experienced during the first phase of the pandemic seemed remote after the summer of 2020, in particular as the language of the marketplace did not relate well to cooperation in a ROAZ network. At the same time, the crisis organization continued to focus on relieving pressure on the intensive care units, the relevant collective in healthcare remained centered around acute hospital care, and the healthcare system stayed in crisis mode. Pre-pandemic relationships, such as those between a dominant university hospital and general hospitals, continued as well, further troubling broader collective action.

3.3. Crisis of coordinating acute care

After the second wave hit, the pressure on Dutch healthcare remained extreme, in part due to the ongoing balancing act between COVID-19 and non-COVID care. The relative calm of the summer of 2020 did not return until spring 2021. During this period, the emergence of the alpha ("British") variant drove fears of a third wave and in fact caused a new pandemic at the end of 2020; the alpha variant was in turn supplanted by the delta variant in the summer of 2021. Anticipation of forthcoming waves fueled the third framing of the crisis that we are exploring here: the pandemic-as-crisis of coordinating acute care. This was mainly defined by anticipation of the moment when, at the national level, there would be such pressure on the Dutch healthcare system that access to the most acute care would no longer be guaranteed, quality standards would be abandoned, and triage on non-medical grounds would be necessary – a scenario that almost became reality in December 2021. This scenario was called Code Black, or Phase 3, and although it inspired fear among our participants, they generally expressed confidence in the perseverance of healthcare professionals:

> And yet, …the thought that we have always had is that Phase 3 will probably never really happen. Formally [Phase 3 might be declared], yes, but emotionally we will have been in it for a long time by then.
>
> (Interview with ROAZ manager, 2021)

Anticipation of Code Black was fed by increasingly prominent epidemiological models and scenario-thinking, but extremely high levels of pressure on care delivery were in fact already occurring, albeit on a smaller scale. For example, at one point all emergency departments in a ROAZ region closed at the same time; at another point, the ambulances in different ROAZ regions were prevented from going on calls due to icy conditions.

The main problem as defined here was a nation-wide occurrence of Code Black, i.e. the need to triage patients based on non-medical criteria. In line with the regional emphasis encountered earlier in the pandemic response, the proposed solution was broader regional coordination between all organizations in the acute care delivery chain – in other words, a more explicit effort to open up the crisis organization to all stakeholders in that chain. Unlike before, this was not a bottom-up movement but followed the national government's explicit instructions to the ROAZ networks in October 2020 to "make local and regional agreements to guarantee the accessibility of care in the broadest sense and to promote and optimize mutual cooperation" (VWS, 2020, p. 6). Work on Code Black arrangements had already started at the national level, in fact well before the outbreak of the pandemic. During the first wave and the summer of 2020, a Code Black triage guideline had been developed, among others with help of ethicists. Having now been mandated to coordinate regional cooperation, the ROAZ networks would become even more of a "spider in the web" of acute care delivery in the region. The regions we observed were actively working on this, and their work largely involved connecting with different stakeholders:

> … that sort of preparation for Code Black, I've always said that as far as I'm concerned, the contents of the plan can go straight into the trash. It's not entirely true, because you have to come up with smart things together, of course, but it's mainly about the conversations and the connections we've made with each other.
>
> (Interview with ROAZ manager, 2021)

There were, for example, clearly connections being made from the hospital to long-term care to facilitate patient transfers. The Code Black plans therefore contributed to a more inclusive approach to the relevant stakeholders in the ROAZ, although always from the point of view of acute care delivery.

Anticipation of Code Black and the ROAZ mandate to develop a concrete regional plan further shifted the balance between central and decentralized efforts to manage healthcare during the pandemic and solidified the use of anticipatory models. It became necessary to spell out relationships on the regional level, although it appeared that the plans were also quickly dismissed in practice. This framing of the pandemic-as-crisis was – at face value – more inclusive than the previous two framings, we suspect because of the more explicit normative aspects of this crisis. For example, the development of the Code Black guidelines at the national level involved a notably broad representation of parties, and the focus on the whole chain of acute care delivery also brought patient representation to the table in developing the guidelines, perhaps bolstering the adaptive capacity of such work as relationships were strengthened. In addition, Code Black preparations raised crucial questions about the quality of care in crises, and about the accountability of healthcare professionals doing their work under such conditions, and as such also afforded ethical reflections about care amid a pandemic. Note, however, that all this was still happening in order to manage the continued pressure on Dutch intensive care units. The hospital sector thus continued to dominate in the crisis organization, and there was still little room to reflect on problems in other sectors of the healthcare system.

4. Discussion

In this paper, we explored the impact of the COVID-19 pandemic on the governance of Dutch healthcare by looking closely at the emerging crisis organization, in particular on the regional level. Our conceptual focus on "crisis" as framing allowed us to observe collective action between healthcare organizations as it emerged at the regional level. We were able to trace the emergence of this collective action not as a response to one monolithic crisis in a healthcare system but rather as a complex, shifting and multi-faceted "metamorphosis" of nested networks of organizational actors amid the mounting uncertainties of the pandemic - a rather self-organizing response (Ansell et al., 2010). On the one hand, framing "the pandemic-as-crisis" in particular ways supported our participants' action amid these uncertainties. A dominant mode of framing what "the crisis" was about helped our participants in the ROAZ networks make sense of what to do, as a particular framing allowed for particular problem definitions and concurrent solutions, delineating the common goods, relevant stakeholders and particular kinds of future about which to be "tact-full" (Kornberger et al., 2019). On the other hand, framing is a dynamic practice and as the dominant framing of "the crisis" shifts over time, definitions of the common goods, relevant stakeholders and legitimate solutions shifted as well. These observations add to current literature on the emergence of collective governance during crisis as we were able to trace such collaborative action and crisis-language as it emerged and changed over time (Ansell and Boin, 2019; Ansell and Gash, 2008). Specific framings of 'the crisis' iteratively shaped our participants' experiences of being an interdependent collective (or not) and concurrent actions. Hence, we argue, discursive action is crucial not only in delineating the relevant issue at hand ('sense-making') and how to effectively communicate such to diverse publics ('meaning-making'), but also in demarcating the collective to be collaborated and governed with. Governing Dutch healthcare amidst the emerging pandemic seemed, in part, to be as much about 'collectivity-making', as it was about sense-making and meaning-making (Ansell and Boin, 2019). The crisis framings we disentangle in this paper emphasize multiple institutional tensions in this 'collectivity-making' in Dutch healthcare amid the evolving pandemic-as-crisis that our participants had to continuously address and readdress, further underscoring the iterative nature and contingencies of collective action and institutional change amid crises.

The first tension we noted was that between centralized and decentralized modes of governing the pandemic, and particularly relevant in the first framing of the pandemic-as-crisis of scarcity. Similar to research in the United Kingdom (Atkinson et al., 2022), we found that tensions between national- and regional-level actors continued throughout the pandemic. The lived and collective affective commitment to dealing with the pandemic became established on the regional and sub-regional levels quite early on. In contrast, in the third framing, we saw the ROAZ networks starting to develop plans in direct response to action from the national government, which the regional levels appeared to accept as well. We see more impactful national-level action at this later stage of the pandemic, such as with the work of distributing patients on a supra-regional level. This work depended on high-quality, valid data, which was not a given and, as we found, involved daily and labor-intensive work. Sharing data and being transparent as an organization while being competitors requires trust. We found such trust, albeit tentatively, more readily experienced on the regional level, where participants had already been cooperating before the start of the pandemic. Our findings thus underscore how centralized crisis management is no panacea. Instead, we also find how self-organizing actions and trust in ROAZ networks enabled the initial response (Beck and Plowman, 2014; Ansell et al., 2010), and how this collective action was bound to specific framings of the pandemic-as-crisis and contingent upon existing institutional logics of the healthcare system.

The second tension we discovered was that between formal and informal modes of managing the pandemic. This tension became particularly salient when the framing of the pandemic-as-crisis of postponed care became dominant. Dutch healthcare professionals have, historically, a strong institutional position in the layered Dutch healthcare system (van de Bovenkamp et al., 2017). Pre-existing and informal networks of professionals self-mobilized to quickly and successfully distribute patients between hospitals, for instance . These high-trust, informal and fast-acting networks can add much-needed resilience to a healthcare system under pressure, especially on the regional level, but they also raise questions of accountability, representation and geographical demarcation. We noticed that the voices of nurses, and patients, but also of long-term and mental healthcare organizations, were not represented in these networks, which because of their informal nature, were also exclusionary (Kuijper et al., 2022). As patients and nurses were also generally excluded from the formal regional crisis organizations, it is important to consider how the advantages of informal networks might be balanced against more structured modes of accountability and more diverse modes of representation. The informal professional networks we found also did not neatly overlap with the geographical demarcations of the Dutch regional crisis organizations, problematizing the "right" geography in implementing crisis measures and requiring additional coordination work – similar to the focus on sub-regions in the ROAZ regions. These findings emphasize the relevance of exploring the layeredness of governing healthcare through networks (van der Woerd et al., 2023), and how framing influences the construction of, and representation in, such collaborative networks.

The third and final tension noted was that between the institutional logic of market-based competition, consensus-based decision-making and top-down coordination in managing healthcare. Coordination efforts, made particularly relevant in framing the pandemic as a crisis of postponed care, went against the grain of the Dutch healthcare system's dominant institutional arrangements. The logic of top-down coordination got in the way of both the logic of regulated competition between healthcare providers and the logic of professional autonomy and consensus-based decision-making. Similarly, there were clear tensions between the logic of consensus-based decision-making – as we saw in the ROAZ networks – and the logic of regulated competition between healthcare providers. As soon as one wave of the pandemic had passed, ideas about competition and doubts about sharing data quickly re-

emerged. Combined with the ever-present possibility of a next wave and a deluge of information, this left our participants few opportunities to construct open "reflexive spaces" (Wiig et al., 2021) for the course and structure of the crisis organization *during* the pandemic, as inter-organizational trust and collaboration were quickly remade into a tentative instead of necessary move for organizations. The new framings of the pandemic-as-crisis hence did not fully subvert existing institutional arrangements, with the latter showing themselves to be structurally resilient in the face of the pandemic (Ewert et al., 2023).

These institutional tensions are not necessarily new in governing the Dutch healthcare system but became much more explicit as a consequence of the multiple pandemics-as-crisis. To account for such longer-term tensions and institutional dynamics, a perspective on crisis management in healthcare that acknowledges and embraces the uncertainties brought about by multiple crises such as the COVID-19 pandemic (Greenhalgh and Engebretsen, 2022; Ansell and Boin, 2019) – instead of a more reductionist mode of anticipatory governance that frames futures as essentially calculable and knowable through scenario-building and statistical means (Rhodes and Lancaster, 2022; Guston, 2014) – appears most useful for building a "resilient" healthcare system. Long-term reorganizations in healthcare with a view to pandemic preparedness, and perhaps even prevention, that consider the relative durability of existing institutional logics and arrangements and the tensions between them appear much more productive than quick fixes and short-term adaptations (Lyng et al., 2021). There *is* no quick fix for pandemic preparedness, but we do wish to emphasize here the need to foster diversity in crisis decision-making in healthcare by organizing countervailing forces and ways to engage with dominant framings of the crisis at hand. For instance, engaging with a more diverse public, including nurses and patients, might more readily lead to broader and perhaps more nuanced framings of the emerging pandemic-as-crisis. Such engagement with broader and more diverse publics might also help in creating ways to deal with institutional tensions that move beyond ad hoc reactions to new waves and new mutations of a virus, and that allow for more diverse and practically grounded perspectives on collective action in the face of mounting uncertainties and new crises.

5. Conclusion

This paper provided an insider's account of the governance of Dutch healthcare system under immense pressure during the emerging COVID-19 pandemic. Our aim was to explore the impact of the pandemic on existing regional collaborations and institutional arrangements. By focusing on "crisis" as framing, we zeroed in on the discursive dynamics and contingencies of our participants' collective action on the regional level in managing the many uncertainties in governing healthcare raised by the pandemic. We were able to follow their collaborative action and crisis-language as it emerged and changed over time and showed how specific framings of the pandemic-as-crisis iteratively shaped collective action. We discussed how this collective action was marred by different institutional tensions as the ROAZ networks we followed developed into the "spider in the web" of acute care, with innovative links being established with long-term care and a new data infrastructure on hospital capacity being constructed. We observed that existing institutional arrangements fueled a dominant focus on hospitals and intensive care, with relatively little input from other sectors, patients or nurses in the crisis organization. The pandemic as such left dominant (regional, symbolic) hierarchies of the healthcare system mostly intact. The changes we did observe interfered, perhaps necessarily so, with existing institutional arrangements in the Dutch healthcare system. We found that the logic of the top-down coordination of care was at odds with the traditionally dominant logics of the market and consensus-based decision-making in governing healthcare, with tensions also arising between the latter two. Existing institutional arrangements thus appeared resilient on a structural level, while the impact of the tensions we identified will become clear in the longer term.

CRediT authorship contribution statement

Bert de Graaff: Conceptualization, Methodology, Formal analysis, Investigation, Funding acquisition, Writing - original draft, Writing - review & editing. **Sabrina Huizenga:** Conceptualization, Methodology, Formal analysis, Investigation, Writing - original draft, Writing - review & editing. **Hester van de Bovenkamp:** Conceptualization, Methodology, Formal analysis, Funding acquisition, Writing - original draft, Writing - review & editing. **Roland Bal:** Conceptualization, Methodology, Formal analysis, Funding acquisition, Writing - original draft, Writing - review & editing.

Data availability

The data that has been used is confidential.

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References

Ansell, C., Boin, A., 2019. Taming deep uncertainty: the potential of pragmatist principles for understanding and improving strategic crisis management. Adm. Soc. 51 (7), 1079–1112. https://doi.org/10.1177/0095399717747655.

Ansell, C., Gash, A., 2008. Collaborative governance in theory and practice. J. Publ. Adm. Res. Theor. 18 (4), 543–571. https://doi.org/10.1093/jopart/mum032.

Ansell, C., Boin, A., Keller, A., 2010. Managing transboundary crises: identifying the building blocks of an effective response system. J. Contingencies Crisis Manag. 18, 195–207. https://doi.org/10.1111/j.1468-5973.2010.00620.x.

Atkinson, P., Gobat, N., Lant, S., Mableson, H., Pilbeam, C., Solomon, T., Tonkin-Crine, S., Sheard, S., 2022. Understanding the policy dynamics of COVID-19 in the UK: early findings from interviews with policy makers and health care professionals. Soc. Sci. Med. 266 (113423) https://doi.org/10.1016/j.socscimed.2020.113423.

Bal, J., de Graaff, B., Vos, M.C., Bal, R., 2022. Mediating scarcity in pandemic times - An ethnographic study on the prevention and control of SARS-CoV-2 infections during the emergence of the corona crisis in the Netherlands. BMC Health Serv. Res. 22, 1407. https://doi.org/10.1186/s12913-022-08843-0.

Beck, U., 2015. Emancipatory catastrophism: what does it mean to climate change and risk society? Curr. Sociol. 63 (1), 75–88. https://doi.org/10.1177/0011392114559951.

Beck, T.E., Plowman, D.A., 2014. Temporary, emergent interorganizational collaboration in unexpected circumstances: a study of the Columbia space shuttle response effort. Organ. Sci. 25 (4), 1234–1252. https://doi.org/10.1287/orsc.2013.0888.

Boin, A., t Hart, P., McConnell, A., 2009. Crisis exploitation: political and policy impacts of framing contests. J. Eur. Publ. Pol. 16 (1), 81–106. https://doi.org/10.1080/13501760802453221.

Boin, A., McConnell, A., 't Hart, P., 2021. Governing the Pandemic – the Politics of Navigating a Mega-Crisis. Palgrave Pivot, Cham. https://doi.org/10.1007/978-3-030-72680-5.

van de Bovenkamp, Hester M., Stoopendaal, A., Bal, R., 2017. Working with layers: the governance and regulation of healthcare quality in an institutionally layered system. Publ. Pol. Adm. 32 (1), 45–65. https://doi.org/10.1177/0952076716652934.

Bröer, C., 2008. Private Trouble, policy issue, how policy discourses shape our experience of aircraft sound. Crit. Pol. Stud. 2 (2), 93–117. https://doi.org/10.1080/19460171.2008.9518533.

Clark, H., Cardenas, M., Dybul, M., Kazatchikine, M., Liu, J., Miliband, D., Nordström, A., Sudan, P., Zedillo, E., Obaid, T., McCarney, R., Radin, E., Eliasz, M.K., McNab, C., Legido-Quicgley, H., Sirleaf, E.J., 2022. Transforming or tinkering: the world remains unprepared for the next pandemic threat. Lancet 399 (10340), 1995–1999. https://doi.org/10.1016/S0140-6736(22)00929-1.

Deml, M.J., Minnema, J., Dubois, J., Senn, O., Streit, S., Rachamin, Y., Jungo, K.T., 2022. The impact of the COVID-19 pandemic on the continuity of care for at-risk patients in Swiss primary care settings: a mixed-methods study. Soc. Sci. Med. 298, 114858 https://doi.org/10.1016/j.socscimed.2022.114858.

Dieminger, L., Kamenshchikova, A., Hoebe, C.J.P.A., Horstman, K., 2022. Perspectives of public health professionals on border control practices for COVID-19 management in Europe. Publ. Health. https://doi.org/10.1016/j.puhe.2022.06.020.

Ewert, B., Wallenburg, I., Winblad, U., Bal, R., 2023. Any lessons to learn? Pathways and impasses towards health system resilience in post-pandemic times. Health Econ. Pol. Law 18 (1), 66–81. https://doi.org/10.1017/S1744133122000238.

Gifford, R.E., van de Baan, F.C., Westra, D., Ruwaard, D., Zijlstra, F.R.H., Poesen, L.T., Fleuren, B.P.I., 2022. There and back again. Examining the development of employee commitment during a prolonged crisis. SSM – Qualitative Research in Health. https://doi.org/10.1016/j.ssmqr.2022.100053.

Graaff, B. de, Bal, J.R., Bal, R., 2021. Layering risk work amidst an emerging crisis: an ethnographic study on the governance of the COVID-19 pandemic in a university hospital in the Netherlands. Health, Risk Soc. 23 (3–4), 111–127. https://doi.org/10.1080/13698575.2021.1910210.

Greenhalgh, T., Engebretsen, E., 2022. The science-policy relationship in times of crisis: an urgent call for a pragmatist turn. Soc. Sci. Med. 306 (115140) https://doi.org/10.1016/j.socscimed.2022.115140.

Greenhalgh, T., Ozbilgin, M., Tomlinson, D., 2022. How covid-19 spreads: narratives, counter narratives, and social dramas. BMJ 378, e069940. https://doi.org/10.1136/bmj-2022-069940.

Guston, D.H., 2014. Understanding "anticipatory governance". Soc. Stud. Sci. 14 (2), 218–242. https://journals.sagepub.com/doi/full/10.1177/0306312713508669.

Hajer, M., 2005. Coalitions, practices and meaning in environmental politics: from Acid Rain to BSE. In: Howarth, D.R., Torfing, J. (Eds.), Discourse Theory in European Politics: Identity, Policy, and Governance. Palgrave Macmillan.

Hay, C., 1996. Narrating crisis: the discursive construction of the "winter of discontent". Sociology 30 (2), 253–277.

Hochschild, A.R., 1979. Emotion work, feeling rules, and social structure. Am. J. Sociol. 85 (3), 551–575.

Jaworski, A., Coupland, N., 1999. The Discourse Reader. Routledge.

Jeurissen, P., Ginneken, E. van, 2019. The Dutch health system in 2019: many major reforms, but still work in progress. Health Pol. 123 (3), 249–251. https://doi.org/10.1016/j.healthpol.2019.02.005.

Kornberger, M., Leixnering, S., Meyer, R.E., 2019. The logic of tact: how decisions happen in situations of crisis. Organ. Stud. 40 (2), 239–266. https://doi.org/10.1177/0170840618814573.

Koselleck, R., Richter, M.W., 2006. Crisis. J. Hist. Ideas 67 (2), 357–400.

Kuijper, S., Felder, M., Bal, R., Wallenburg, I., 2022. Assembling care: how nurses organise care in uncharted territory and in times of pandemic. Sociol. Health Illness 1–19. https://doi.org/10.1111/1467-9566.13508.

Lange, M. de, Carvalho, A.S., Brito Fernandes, Ó., Lingsma, H., Klazinga, N., Kringos, D., 2022. The impact of the COVID-19 pandemic on hospital services for patients with cardiac diseases: a scoping review. Int. J. Environ. Res. Publ. Health 19 (3172). https://doi.org/10.3390/ijerph19063172.

LNAZ, 2020. Opschalingsplan COVID-19. Bureau LNAZ juni 2020. https://www.lnaz.nl/cms/files/opschalingsplan_covid-19_def.pdf.

Lopez, P.J., Neely, A.H., 2021. Fundamentally uncaring: the differential multi-scalar impacts of COVID-19 in the U.S. Soc. Sci. Med. 272 (113707) https://doi.org/10.1016/j.socscimed.2021.113707. ISSN 0277-9536.

Lyng, H.B., Macrae, C., Guise, V., Haraldseid-Driftland, C., Fagerdal, B., Schibevaag, L., Alsvik, J.G., Wiig, S., 2021. Balancing adaptation and innovation for resilience in healthcare – a metasynthesis of narratives. BMC Health Serv. Res. 21 (759) https://doi.org/10.1186/s12913-021-06592-0.

Marres, N., 2007. The issues deserve more credit: pragmatist contributions to the study of public involvement in controversy. Soc. Stud. Sci. 37 (5), 759–780.

Mizee, M., Schaap, L.A., Hoogendijk, E.O., van Schoor, N.M., 2022. Delay or postponement of medical care among older adults in The Netherlands at earlier and later stages of the COVID-19 pandemic. Aging Clin. Exp. Res. https://doi.org/10.1007/s40520-022-02266-x.

Oosterlynck, S., Swyngedouw, E., 2010. Noise reduction: the postpolitical quandary of night flights at Brussels airport. Environ. Plann. 42, 1577–1594.

Orlikowski, W., Gash, D., 1994. Technological frames: making sense of information technology in organizations. ACM Trans. Inf. Syst. 12 (2), 174–207.

Rein, M., Schön, D., 1993. Reframing policy discourse. In: Fischer, F., Forester, J. (Eds.), The Argumentative Turn in Policy Analysis and Planning. Duke University Press, pp. 145–166.

Rhodes, T., Lancaster, K., 2022. Making pandemics big: on the situational performance of Covid-19 mathematical models. Soc. Sci. Med. 301, 114907 https://doi.org/10.1016/j.socscimed.2022.114907.

Sachs, J.D., Karim, S.S.A., Aknin, L., Michie, S., 2022. The Lancet Commission on lessons for the future from the COVID-19 pandemic. Lancet 400, 1224–1280. https://doi.org/10.1016/S0140-6736(22)01585-9.

Stone, D.A., 2012. Policy Paradox: the Art of Political Decision Making. W.W. Norton.

Tavory, I., Timmermans, S., 2014. Abductive Analysis – Theorizing Qualitative Research. University of Chicago Press.

VWS, 2020. Tijdelijk beleidskader voor het waarborgen acute zorg in de COVID-19 pandemie. Ministerie van Volksgezondheid, Welzijn en Sport, Kamerbrief 1770002-213134-CZ, 23-10-2020. https://www.rijksoverheid.nl/documenten/kamerstukken/2020/10/23/kamerbrief-tijdelijk-beleidskader-waarborgen-acute-zorg-in-covid-19-pandemie.

Wallenburg, I., Jeurissen, P., Helderman, J., Bal, R., 2020. The Netherlands' Response to the Coronavirus Pandemic. CambridgeCore blog. https://www.cambridge.org/core/blog/2020/04/06/the-netherlands-response-to-the-coronavirus-pandemic/.

Wallenburg, I., Graaff, B. de, Bal, J., Felder, M., Bal, R., 2021. Dancing with a virus: finding new rhythms of organizing and caring in Dutch hospitals. In: Waring, J., Denis, J.L., Pedersen, A.R., Tenbensel, T. (Eds.), Organizing Care in a Time of Covid-19, Organizational Behaviour in Healthcare. Palgrave Macmillan, pp. 121–138.

Wiig, S., Aase, K., Bal, R., 2021. Reflexive spaces: leveraging resilience into healthcare regulation and management. J. Patient Saf. 17 (8), e1681–e1684. https://doi.org/10.1097/PTS.0000000000000658.

Woerd, O. van der, Janssens, J., van der Scheera, Wilma, Bal, R., 2023. Managing (through) a network of collaborations: a case study on hospital executives' work in a Dutch urbanized region. Publ. Manag. Rev. https://doi.org/10.1080/14719037.2023.2171093.

Yanow, D., 2000. Conducting Interpretive Policy Analysis. Sage Publications.